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REPORT
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HEALTH SERVICES, PREVENTIVE HEALTH SERVICES, AND HOME AND COMMUNITY BASED SERVICES ACT OF 1984

APRIL 12 (legislative day, MARCH 26), 1984.—Ordered to be printed

Mr. HATCH, from the Committee on Labor and Human Resources, submitted the following

REPORT

together with

ADDITIONAL VIEWS

[To accompany S. 2301]

The Committee on Labor and Human Resources to which was referred the bill (S. 2301) to revise and extend programs for the provision of health services and preventive health services, to establish a program for the provision of home and community-based services, and for other purposes, having considered the same, reports favorably thereon with amendment(s) and recommends that the bill (as amended) do pass.

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I. Summary of Bill

EXTENSION OF THE PREVENTIVE HEALTH AND HEALTH SERVICES (PHHS) BLOCK GRANT

S. 2301 extends the Preventive Health and Health Services (PHHS) Block authority for three fiscal years and authorizes appropriations of $93 million for FY 1985, $97 million for FY 1986, and $102 million for FY 1987. In its extension of the PHHS Block authority, the Committee's bill also repeals the requirement that States fund hypertension programs in FY 1982, 1983, and 1984 at specific percentages of amounts awarded in the State in FY 1981 under the prior categorical authority consolidated in the block. These percentages have been 75 percent for FY 1982, 70 percent for 1983, and 60 percent for FY 1984.

EMERGENCY MEDICAL SERVICES FOR CHILDREN

The Committee's bill revises the list of activities for which States have been able to use their PHHS Block allotments. Specifically, the bill broadens the emergency medical services activity to allow States to use their allotments for the establishment, expansion, and improvement of emergency medical services for children who need treatment for trauma or critical care, and eliminates the current prohibition of purchase of E.M.S. equipment.

The bill also provides within the PHHS Block authority a new and separate authorization for demonstration grants to support projects for the expansion and improvement of emergency medical services for children who need treatment for trauma or critical care. The bill authorizes for these demonstration grants $2 million for each of the fiscal years 1985 through 1987 and specifies that grants could be awarded to no more than four States in any fiscal year. Grants would be for a one-year period, unless the Secretary determines that renewal, for an additional one-year period only if the Secretary determines that renewal would provide significant benefits through the collection, analysis, and dissemination of information or data useful to other States.

STATE PLANNING CONCERNING HEALTH PROMOTION AND DISEASE PREVENTION

The Committee's bill authorizes grants to States to assist them to:

(1) Develop long-range plans to achieve the goals, objectives, and priorities established by the Secretary under the Health Information and Promotion authority contained in title XVII of the Public Health Services Act;

(2) Identify particular needs within States for the services and activities that may be conducted under the PHHS Block; and

(3) Determine the progress that has been made in achieving the goals, objectives, and priorities identified in their long-rang plans, using to the extent feasible, scientifically valid measures for these determinations.

The Committee's bill establishes a separate authority for these grants to the States under the PHHS Block grant (Part A of title

XIX of the Public Health Service Act) and authorizes $5 million for each of the FY 1985 through 1987.

HOME AND COMMUNITY-BASED SERVICES BLOCK GRANT

The bill establishes within the PHHS Block authority a separate Home and Community-Based Services Block grant program to the States. For this block grant program, the bill authorizes $20 million for FY 1985 for program planning; and $150 million for FY 1986 and $200 million for FY 1987 and $200 million for FY 1988 for home and community-based activities and services. States could use their fiscal year 1986 through 1988 allotments for:

(1) Activities to coordinate long-term care services provided to elderly and disabled persons by public and private institutions and voluntary organizations in order to eliminate duplication and to maximize the use of funds;

(2) The development of procedures and means to identify and assess elderly and disabled persons in need of home and community-based services; making recommendations for cost-effective measures to meet these needs; and encouraging the participation of families and voluntary organizations to provide home and community-based services;

(3) Identifying and assessing individuals in need of community-based services; and

(4) The provision of certain home and community-based services.

DATA COLLECTION AND INFORMATION

The Committee's bill requires the Secretary in consultation with appropriate national organizations, to develop model criteria and forms for the collection of data and information on services provided under the revised PHHS Block authority, to enable States to share uniform data and information on these services.

EXTENSION OF VARIOUS PREVENTIVE HEALTH AND HEALTH SERVICES PROGRAM

The Committee's bill extends for three fiscal years the authorities of programs which provide grants for: (1) childhood immunizations; (2) tuberculosis control; (3) venereal disease control; and (4) home health programs in areas where services are inadequate or not readily accessible and programs for home health care paraprofessionals (including homemaker home health aides).

II. Background

In 1981, with the enactment of the Omnibus Budget Reconciliation Act, P.L. 97–35, Congress consolidated a number of categorical health programs into four health block grants. One of the blocks established at this time was a Preventive Health and Health Services (PHHS) Block Grant, which consolidated eight Federal categorical health programs into a single authority of grants to the States. Under this block, States have been the recipients of allotments which may be used for purposes similar to the activities con-

ducted under the categorical authorities consolidated in the block. Specifically, States may use their allotments for:

(1) Preventive health service programs for the control of rodents;

(2) Preventive health service programs for school-based fluoridation programs;

(3) Establishing and maintaining screening, detection, diagnosis, prevention, treatment, and follow-up programs for hypertension;

(4) Community-based programs for demonstrating and evaluating optimal methods for organizing and delivering comprehensive preventive health services to defined populations, comprehensive programs designed to deter smoking and the use of alcoholic beverages among children and adolescents, and other risk-reduction and health education programs;

(5) Comprehensive public health services;

(6) Encouraging the establishment of home health agencies in areas where the services of such agencies are not available;

(7) Feasibility studies and planning for emergency medical services systems and the establishment, expansion, and improvement of such systems; and

(8) Providing services to rape victims and for rape prevention.

Appropriations for the PHHS Block are allotted to the States according to the percentage of funds received by the State or entities within the State in FY 1981 of the total amounts awarded in that year under the various categorical programs included in the block. For services for rape victims and for rape prevention, the block contains a special set-aside; of the amount appropriated in any fiscal year for the PHHS Block, at least $3 million must be allotted to the States on the basis of population and made available for these services.

The PHHS Block has contained a number of other specifications as to how States may spend their allotments. In FY 1982, States were required to award emergency medical services grants and contracts to those entities which were funded in the State in FY 1981 and which would have been eligible for Federal assistance in FY 1982. In addition, States have been required to make grants for hypertension programs during each of the fiscal years 1982 through 1984. Specifically, the PHHS Block has required States to fund hypertension programs at 75 percent, 70 percent, and 60 percent in FY 1982, FY 1983 and 1984, respectively, of the amounts awarded in the State in FY 1981.

The PHHS Block became effective October 1, 1981. In a survey of 13 States' implementation of the PHHS Block, the General Accounting Office (GAO) found that States have generally assigned PHHS Block grant responsibilities to State offices which had administered the prior categorical programs and have made only minimal changes to their organization or service provider network. GAO also found that States have been obtaining input for making decisions on how to use block grant funds from several sources including hearings and advisory groups. In addition, program officials have noted that governors and legislatures have become more involved in program decisions.

GAO also reported at Committee hearings that the types of services offered under the PHHS Block were essentially the same as those provided under the categorical programs. However, States have modified certain program priorities. Generally, States have given higher priority to program areas where they previously had greater involvement in making funding and program decisions. Specifically, States had considerable involvement in prior health incentive, hypertension, fluoridation, and health education and risk reduction categorical programs. Although there were variations across the 13 States surveyed by GAO, the percentage of total expenditures spent for these program areas was generally maintained or increased. In addition, States found little reason to adjust the types of services provided in these four program areas.

In contrast, States had more limited control over Federal emergency medical services and rodent control funds, and under the block grant many assigned these program areas a lower priority and initiated more changes in services.

III. History of S. 2301, Including Hearings

A bill, S. 2301, to extend programs for the provision of health services and preventive health services, to establish a program for the provision of home and community-based services, and for other services was introduced by Senator Hatch on February 9, 1984, and referred to the Committee on Labor and Human Resources.

Two public hearings were held by the Committee related to this legislation. On February 22, 1984, testimony was presented by Dr. Edward N. Brandt, Assistant Secretary for Health of the Department of Health and Human Services. On March 7, 1984, testimony was presented by:

Mr. Richard Fogel, Director, Human Resources Division of the U.S. General Accounting Office.

Mr. John Tierney, Chairman, Management Committee, Association of State and Territorial Health Officials; Deputy Director, Rhode Island Department of Health, Providence, Rhode Island.

Written testimony was submitted by: American Academy of Pediatrics, American Dental Association, American Lung Association, American Social Health Association, The Honorable Daniel K. Inouye, U.S. Senator from Hawaii, National Coalition of Emergency Medical Services, and National Conference of State Legislatures.

On March 21, 1984, the Committee met in open executive session to consider an amended version of the bill which incorporated the recommendations and comments of members of the Committee, professional societies, the Administration, and interested individuals. The bill as amended was ordered reported favorably to the Senate.

IV. Committee Views

The Preventive Health and Health Services (PHHS) Block has proved to be an effective mechanism by which to maintain a Federal commitment to important national health objectives while attempting to ensure that resources are focused on real needs and problems. The PHHS Block has functioned as this Committee expected when it authorized the program in 1981. It has provided

States greater freedom and flexibility to target resources on areas of highest priority, as these are defined by State and local governments. In addition, the block has also contributed to an improved planning process by allowing greater consistency, uniformity, and control in the administration of preventive health and health services programs. It has done so not only by providing States greater responsibility and authority for decisions on the expenditure of funds, but also by streamlining Federal regulations and easing the Federal administrative burden that accompanied the various categorical programs consolidated in the block.

To this point of administrative simplification under the block, the Committee notes preliminary findings of GAO's survey of States' implementation of the PHHS Block. According to State officials interviewed by GAO, the block grant has enabled eight of the 13 States surveyed to change or standardize their administrative requirements, seven to improve planning and budgeting, three to better use State personnel, ten to reduce the time and effort associated with preparing grant applications, and 12 to reduce the time and effort involved in reporting to the Federal Government.

GAO also noted in their testimony before the Committee that States have taken their expended administrative role seriously and have often integrated grant management activities with ongoing State efforts for other related programs. These observations correspond to findings of another survey of health block grants. The Urban Institute noted at briefings on preliminary findings of their 18 State survey of health block grants that States in the main seem to have acted responsibly with their new authority, undertaking careful planning and making reasonable priority judgments according to their own circumstances. However, analysis of the State programs under the PHHS Block has been compromised by lack of accountability and uniform data.

The Committee is impressed with other findings of both the Urban Institute and GAO that health programs consolidated in the PHHS Block have benefited in certain States from increases in State funds available for the activities conducted under the block. These increases in State funding came at a time of serious State and local fiscal problems and at a time of reductions in Federal funding for health blocks. In 1981, when Congress considered consolidation of categorical programs into health block grants, opponents of the concept asserted that States would not remain committed to funding human services programs. Urban Institute and GAO findings indicate that this has not been the case and that health programs are a high priority for the States.

For these various reasons, the Committee's bill extends the current PHHS Block authority and includes several amendments which are intended to allow States to be even more responsive to their individual needs and problems. With a three-year extension of the PHHS Block, the Committee indicates the importance it attaches to maintaining a Federal commitment to the preventive health and health services activities conducted under this authority. At the same time, the Committee wishes to emphasize that this commitment can be most effectively carried out through the block grant approach. Most available evidence points to the effectiveness of the consolidation accomplished in 1981. Extension of the PHHS

Block will likely allow States to achieve additional efficiencies in the provision of services.

The Committee has proposed authorization levels for the PHHS Block higher than fiscal year 1984's appropriation level facilitating operation at current service levels: $93 million for fiscal year 1985, $97 million for fiscal year 1986, and $102 million for fiscal year 1987. The Committee has specified these authorization levels for the PHHS Block to assist States in addressing outstanding problems at a time of increasing health care costs. However, the Committee is also aware of the need to limit Federal spending if large Federal deficits are to be reduced. These authorization levels are intended to provide sufficient flexibility for funding the PHHS Block at current service levels to the extent that budgetary constraints allow.

In addition, it should be noted that the Committee's bill repeals an unnecessarily restrictive PHHS Block requirement for States to fund hypertension programs at specified levels. Preliminary findings from the GAO survey indicate that hypertension programs have continued to be a relatively high priority in most States, and that aside from changes related to funding adjustments, States reported continuing essentially the same types of services that were supported under the categorical program.

The Committee, however, wishes to emphasize and strongly recommend that States continue to give high priority to high blood pressure screening, detection and follow-up programs. The States' efforts in this area should be designed to complement and to overlap with the tremendous efforts undertaken by local government, private groups and physicians to address the high blood pressure problem.

The importance of blood pressure control has been emphasized in Federal policy since the passage of the National Heart, Blood Vessel, Lung and Blood Act of 1972. It was reaffirmed as a high priority of the U.S. Department of Health and Human Services in the 1983 Surgeon General's report, "Promoting Health/Preventing Disease: Public Health Service Implementation Plans for Attaining the Objectives for the Nation."

Hypertension is a disease which afflicts 60 million Americans. It has no symptoms and is responsible for the deaths of as many as 31,000 Americans annually. The American Heart Association estimates that of the 37 million Americans afflicted with essential hypertension, as many as many as 46% of that amount are unaware of their condition. Only 15% of the 37 million are receiving adequate treatment. Despite the obvious success of public and private blood pressure control programs, these statistics support the need to maintain efforts to control blood pressure as one of the nation's top disease prevention priorities. Hypertension, though asymptomatic, can be discovered through screening and controlled. It is essential that cost-effective, on-going high blood pressure screening remain a key component of this nation's preventive health care strategy:

EMERGENCY MEDICAL SERVICES FOR CHILDREN

The Committee is concerned about the availability of emergency medical services for children. Of all the patients receiving care in hospital emergency departments, approximately 20 to 35 percent are children or adolescents. Yet various statistics suggest that insufficient attention has been placed on the needs of children. In fact, acccidents have become the largest single cause of death and disability for those between the ages of land 14 years. The Committee believes that while our emergency medical services programs have demonstrated extraordinary ability to save lives, special priority needs to be given to upgrading their capacity to provide emergency care for children who are critically ill.

The Committee's bill contains two provisions which are designed to assist States to give priority to the emergency medical services needs of children. First, the bill revises the list of activities for which States have been able to use their PHHS Block allotments, to broaden the emergency medical services activity to allow States to use their allotments for the establishment, expansion, and improvement of emergency medical services for children who need treatment for trauma or critical care.

Second, the Committee's bill provides within the PHHS Block authority a new and separate authorization for demonstration grants to the States to support projects which will expand and improve emergency medical services for children who need treatment for trauma or critical care. The bill authorizes for these demonstration grants $2 million for each of the fiscal years 1985 through the 1987 and specifies that grants could be awarded to no more than four States in any fiscal year. Grants would be for a one-year period, unless the Secretary determines that renewal for an additional one-year period only would provide significant benefits through the collection, analysis, and dissemination of information useful to other States.

It is the committee's intent that these demonstration projects shall be catalysts or "seed" projects, which are expected to result in generating financial support from local and private resources for their continuation, and the establishment of similar projects in other localities. Accordingly, the committee expects that the Department will establish them in a manner that will ensure at a minimum, maximal geographical distribution, and further that a conscious effort will be made to give priority to applications that are targeted towards serving populations with truly special needs, such as minorities (including native Americans) and handicapped children. The committee is aware, for example, of the considerable interest of the University of Connecticut, the University of Utah, and the University of Hawaii in submitting proposals under this initiative to develop innovative approaches for their respective populations.

STATE PLANNING CONCERNING HEALTH PROMOTION AND DISEASE CONTROL

The enactment in 1976 of P.L. 94-317 added a new title XVII, Health Information and Health Promotion, to the Public Health Service Act. Among other things, the new title XVII authorized the

Secretary to formulate national goals with respect to health information and health promotion, preventive services, and education in the appropriate uses of health care, as well as the strategy to achieve such goals.

Three years later, in 1979,, the Surgeon General published a report called "Healthy People," which serves as the basis of the Department's current overall effort in the area of disease prevention and health promotion. "Healthy People" presented health goals for five age groups—infants, children, adolescents and young adults, adults, and older adults. Some of these goals were general; others specified quantitative targets to be attained by 1990, such as reductions in mortality for the four groups under 65 years of age.

In 1980, the Department released a second key document: "Promoting Health/Preventing Disease, Objectives for the Nation," which set forth specific objectives for 15 priority areas. These objectives, which were set for 1990, were designed to facilitate progress toward the broader goals set forth in "Healthy People" by specifying targets. The 15 areas of health, grouped into three categories, which should receive priority in order for the goals to be attained, are:

Preventive Health Services

1. High Blood Pressure Control.
2. Family Planning.
3. Pregnancy and Infant Health.
4. Immunization.
5. Sexually Transmitted Disease Control.

Health Protection

6. Toxic Agent and Radiation Control.
7. Occupational Safety and Health.
8. Accident Prevention and Injury Control.
9. Flouridation and Dental Health.
10. Surveillance and Control of Infectious Disease.

Health Promotion

11. Smoking Control.
12. Misuse of Alcohol and Drugs.
13. Improved Nutrition.
14. Physical Fitness and Exercise.
15. Control of Stress and Violent Behavior.

The Department developed the specific measurable objectives for the 15 priority areas with the participation of more than 500 individuals and organizational representatives from the public and private sectors. The 1980 report which listed these objectives emphasized that their achievement could be realized only through a commitment that was national in scope. The report noted that success would depend on a "sustained commitment from every level of society: in Federal, State, and local government agencies; in industry and labor; in voluntary health organizations; in schools and churches; among physicians and other health workers; and among private citizens."

The Department developed implementation plans for the 15 priority areas that were designed to lead to the achievement of specif-

ic objectives by 1990. An agency or office of the Department was designated to serve as lead agency for each of the 15 areas. The lead agencies were chosen on the basis of their program or statutory responsibilities in the 15 areas. Each lead agency monitors trends, developments, and progress in meeting the objectives, as well as problems along the way. Regular review sessions within the Public Health Service are used to gauge progress and provide feedback for possible changes in objectives and implementation plans.

The committee is concerned that current assessment of needs and measurement of progress toward priority goals is deficient. To build upon these various activities and to assure additional progress in meeting national health promotion and disease prevention goals and objectives, the Committee's bill authorizes grants to the States to assist them with developing long-range plans for health promotion. With new authority, control, and responsibilities provided under the health block grants established in 1981, States have become highly sensitive to their individual needs and priorities, and because of this, are in an excellent position to initiate long-range plans for addressing health problems.

The Committee's bill specifically authorizes grants to States to assist them to: (1) develop long-range plans to achieve the goals, objectives, and priorities established by the Secretary under the Health Information and Promotion authority contained in title XVII of the Public Health Services Act; (2) identify particular needs within the States for the services and activities that may be conducted under the PHHS Block; and (3) determine the progress they have made in achieving the goals, objectives, and priorities identified in their long-range plans, using to the extent feasible, scientifically valid measures for these determinations. The Committee's bill authorizes for these grants $5 million for each of the fiscal years 1985 through 1987.

HOME AND COMMUNITY-BASED SERVICES BLOCK GRANT

The Committee's bill establishes within the PHHS block authority a separate Home and Community-Based Services Block grant program to the States. For this block grant, the bill authorizes $20 million for FY 1985 for program planning; and $150 million for FY 1986, $200 million for FY 1987, and $200 million for FY 1988 for home and community-based activities and services.

These provisions of S. 2301 are very similar to a bill S. 1539, originally introduced in June 1983 and included in S. 242, the Employment Opportunities Act of 1983, reported by this Committee July 14, 1983. They differ from the orginially reported legislation in three principal ways: (1) Authorization levels have been reduced. (2) The list of home and community-based services which can be provided with allotments has been narrowed by excluding skilled nurse and physician services. (3) The formula for allocating funds to the States has been revised to reflect the proportion of a State's population that is elderly. Whereas orginally allotments would have been made to the States on the basis of the ratio of the total number of elderly individuals residing in a State to the total number of elderly individuals in all States, the revised formula allocates funds to the States on the basis of this same ratio multi-

plied by a weighting factor of the proportion of a State's population that is elderly compared to the proportion of the Nation's population that is elderly.

By including Home and Community-Based Services Block provisions in S. 2301, the committee emphasizes and affirms its commitment to an approach which is particularly relevant and appropriate at this time. The Committee is well aware that the present system of long-term care in the country is biased toward institutional care and that publicly financed health programs provide substantially more support for hospital and nursing home care than for home health and other community-based services. The Committee is also convinced that home and community-based care can result in significant cost-savings over the long-run for elderly and disabled individuals. Unless viable community-based services are developed to prevent unnecessary institutionalization of the elderly and disabled, the Nation can only expect that the number of persons in nursing homes will grow, especially as the proportion of elderly individuals in the population increases at a faster rate than other age categories.

The Committee believes that the block grant approach for home and community-based services is especially relevent at this time. Over the past several years, States have begun to focus increased attention on restructuring their existing policies and programs on long-term care. States have established commissions or task forces to plan for a reorientation for State programming and/or have developed new approaches to the coordination of available Federal and State funds to support a variety of community-based services.

A block grant for home and community-based services will assist the States and localities not only by providing support for planning and coordinating existing localities and coordinating existing Federal, State, and local programs for community-based long-term care, but also by providing assistance for an expansion of services. The Committee believes that it is important to build upon past and current State activities and not create another Federal program having still one more set for requirements for the States. The Committee's block grant approach will provide the necessary incentives for improving the current system of care by allowing States to continue and/or initiate innovative programs to coordinate and expand their long-term care systems. At the same time, a block grant will assure States the flexibility they need to provide services efficiently and effectively.

The Committee would like to point out one particularly successful State program whose services and activities it expects would be provided across the Nation with Home and Community-Based Services Block funds. In 1981, Oklahoma launched an Eldercare Program to provide community-based health and social services for the frail, noninstitutionalized aged. This program was established as part of the Preventive Medical Service of the Oklahoma State Department of Health and administered through the Chronic Disease and Home Health Care Division. An advisory committee representing a coalition of aging interests, the State Aging Agency, the State Mental Health Agency, and the State Health Planning Commission has been active throughout the project, particularly as a source for recommendations to the Commissioner of Health regarding loca-

tions of the demonstration sites, the design of the program, evaluation procedures and related issues.

The stated objectives of the Eldercare Program are:

(1) To eliminate or postpone the necessity for institutional care for the aged and aging in Oklahoma.

(2) To coordinate the existing system of fragmented, specialized services at the community level.

(3) To stimulate the development of needed new services only when there is no other alternative available to meet the needs of the aged and aging.

(4) To promote the development of a network of volunteer support services at the community level.

(5) To demonstrate the cost effectiveness of home and community-based alternatives to institutional care; and

(6) To serve as models for all Oklahoma communities seeking effective and efficient mechanisms to assist older citizens in the management of health and social problems which accompany the process of maturing in this society.

Basic service components provided by contracted demonstration sites have included the following:

(1) Central point of intake in each jurisdiction.

(2) Comprehensive client assessment procedures using standardized assessment instruments.

(3) Service management, including service planning, arranging for services, and monitoring and reassessment of client status.

(4) Resource mobilization, involving identification and involvement of all sources of assistance for clients of the program including volunteer groups and family members.

(5) Public information and education activities.

(6) Agreements with local agencies and advisory committee development.

(7) Program management and evaluation.

An evaluation of Oklahoma's Eldercare program has shown that it is possible to assemble within a single organizational setting different types of health and social services which to a major degree in the past were not operated within a single program setting. In addition, it appears that the demographic characteristics of the populations being served in Oklahoma do not differ significantly from those served by similar programs in other States. The typical client is female, in her 70's, widowed or living alone with a variety of health and social needs. Almost 2 out of 3 describe their health status as poor and demonstrate major limitations in being able to perform activities of daily living. Major needs include assistance in meal preparation, homemaking and housekeeping activities as well as in transportation.

What is especially impressive, the Eldercare program has demonstrated that it is possible to provide services economically. While available data are limited to a relatively small number of the over 10,000 clients served thus far, an evaluation of the economic impact of the program found that:

—Despite the relatively low costs of nursing home care in Oklahoma ($875.00 per month), the Eldercare program has com-

pared most favorably with a direct cost of only $62.50 per client served per month.

—In addition, there is evidence that the program provides a much wider range of services to those served than do the traditional nursing homes in this State.

—The direct cost of $62.50 per client per month has generated $76.45 per client per month in third party payors expenditures and $128.87 in volunteer and family provided expenditures.

Oklahoma obviously exemplifies those States which have already done a great deal of work to coordinate existing social and health services and identify those most in need of such services. Under this new block grant authority, States like Oklahoma would have the flexibility to use their alloted funds to provide basic support services, without expending funds for planning and development which has already been accomplished.

The Committee is aware that many chronically ill elderly and disabled individuals are, in fact, more economically and appropriately cared for in long term care facilities. A recent GAO study indicated that home care for severely disabled and debilitated individuals may be more expensive than institutional care. The intention of the committee is to authorize services which will reduce the number of individuals inappropriately hospitalized or institutionalized simply because community services are not available. At the same time, the committee recognizes that for community and home services to be cost effective, the total cost of services provided an individual must be less than the cost of institutional care for that individual. Therefore, the committee has included a statutory requirement that the cost of services per individual must not exceed the cost of institutionalization for that individual.

Recognizing that long term care is provided through a variety of federal, state and county programs, including private, public, proprietary and non-proprietary organizations, the committee wishes to emphasize the importance of coordination and avoiding duplication of services.

It is well known that a sizable portion of hospital patients are backed up and awaiting placement in either a nursing home or their own home. A 1980 one day survey of over 4,000 hospitals found well over 13,000 patients waiting to be placed in a long term care institution or home setting with services. Identification of such individuals, coupled with the coordination and provision of services authorized by this bill should alleviate this expensive and extensive problem.

DATA COLLECTION AND INFORMATION

The Committee's bill requires the Secretary, in consultation with appropriate national organizations, to develop model criteria and forms for the collection of data and information on services provided under the revised PHHS Block authority, to enable States to share uniform data and information on these services. At Committee hearings, the Association of State and Territorial Health Officials (ASTHO) testified that an area of growing concern among the nation's State health officers is the need for a voluntary system for national uniform information on the uses of block grant funds.

ASTHO indicated that maintaining public confidence and adequate funding for the highly flexible block grants hinges on the States' ability to describe in national, uniform terms, the vital services supported with block grant funds.

The Committee is aware that a voluntary, cooperative data system has been established by the states to provide accountability for block grant funds, and finds this arrangement preferable to federally specified reporting requirements. Therefore, the Committee urges the DHHS to assist the state health departments in strengthening their voluntary data system, by providing them with the financial and technical resources necessary to produce the kinds of uniform and timely information needed by the Congress.

The Committee's bill is intended to provide the stimulus required for the development of a model, uniform data collection instrument and process which would be useful to States for whatever data collection efforts they may wish to undertake. The Committee's amendment is not intended to return the PHHS block to the extensive mandated reported requirements which existed under the categorical programs consolidated in the block. Nor does the Committee expect that the model instrument developed under this provision will result in a burdensome or expensive data collection process for the States.

EXTENSION OF VARIOUS PREVENTIVE HEALTH AND HEALTH SERVICES PROGRAMS

The Committee's bill reauthorizes the childhood immunization, tuberculosis, venereal disease, and home health programs for fiscal years 1985, 1986, and 1987. These programs provide high-priority preventive health and other health services and are carried out in a partnership between the Federal government, States, and localities. The Committee believes that they are important programs, critical to our Nation's public health.

Specifically the childhood immunization program is authorized at levels of $42.4 million, $47 million, and $51 million for fiscal years 1985, 1986, and 1987, respectively. Appropriate administration of safe vaccines is one of the most cost-effective methods for preventing human suffering and reducing costs resulting from vaccine-preventable disease. The Committee notes that immunization levels are at an all-time high of 95 percent, and cases of measles, rubella, tetanus, polio, and mumps have reached all-time lows. With the authorization levels specified in its bill, the Committee intends to assure high levels of immunization, especially at a time of increasing costs for vaccines, and to provide support for D.P.T. vaccination programs. The committee is also aware that there is growing concern about the safety of vaccine products, as well as tremendous cost increases, and has scheduled further hearings to address issues related to vaccine injury compensation and development of safer vaccines.

For projects and programs for the prevention and control of venereal disease, the Committee's bill authorizes $50 million, $55 million, and $55 million for fiscal years 1985 through 1987. Although the programs for the prevention and control of venereal disease have made great strides in recent years in the treatment of gonor-

rhea and syphilis, the Committee believes that there is still room for improvement. In 1984, it is estimated that outreach programs will provide services to 9.3 million adolescents and young adults. These efforts will prevent an estimated 6,500 cases of syphilis and more than 179,000 cases of gonorrhea and will result in the treatment of more than 760,000 venereal-disease patients. Currently, the veneral disease control program is focused primarily on syphilis and gonorrhea, but other sexually transmitted diseases are on the increase in this country. Research and treatment of genital herpes, chlamydia infections, and other causes of nongonococcal urethritis are two problems which should receive additional attention. The Committee is concerned that many of the victims of sexually transmitted disease are infants who acquire these disease at birth. Increased emphasis should be appropriately placed on prenatal and neonatal care of these children.

In 1978 this Committee amended the Venereal Diseases Prevention and Control Program so that 5% of all funds appropriated to the program be allocated to projects of public information, education, research and demonstration. The Committee is disappointed that in the intervening years only a handful of projects have been funded in this area. Of these funded projects, the Committee wishes to note the value of the VD National Hotline. Accordingly, the Committee intends that the Hotline be continued and that expansion be considered. The Hotline provides information and referral to thousands of callers in need. The Committee notes the importance of public education projects for the prevention and control of VD, but is concerned that public education was low on the list of priorities in recent Departmental Request for Proposals. Public education is the first line of prevention, and the Committee hopes the DHHS will direct funds toward programs which can be of benefit nationally, especially to young people.

The Committee is concerned about professional education regarding sexually transmitted diseases. A study published in the Journal of the American Medical Association detailed the training American medical schools are providing for medical students. The Committee believes that training of health professionals should become a higher priority of the Sexually Transmitted Disease (STD) Control program.

The bill also authorizes preventive health service programs for tuberculosis at levels of $8 million, $9 million, and $10 million for fiscal year 1985, 1986, and 1987 respectively. This compares to the fiscal year 1984 appropriation of $5 million. Tuberculosis is still a major health concern and risk throughout the Nation. Particularly in large cities and areas that have experienced significant refugee influx. Tuberculosis is medically treatable. The continuation of efforts to curb its growth could lead to its ultimate eradication. The Committee believes that continuation of tuberculosis outreach programs to high incidence areas is a priority preventive health service for the Federal Government and therefore extends its categorical authority at the authorization levels indicated above.

The Committee's bill also extends the authority for grants and loans for the establishment of home health programs in areas where services are inadequate or not readily accessible. This authority also supports training programs for home health care per-

sonnel, including homemaker home health aides. The bill authorizes $5 million for each of the fiscal years 1985 through 1987 for grants and loans for home health programs and $2 million for each of the fiscal years 1985 through 1987 for home health training. In many areas of the country, frail elderly and disabled persons do not have access to home and community-based services for the reason that home health care agencies and home health care personnel are in short supply. It is the purpose of the Committee's extension of this program to assist in the development of resources where these are currently inadequate.

The Committee incorporated into the bill a provision to direct the Secretary of Health and Human Services to conduct a study of Title VI of the Public Health Service Act to determine whether the regulations implementing the Hill-Burton program should distinguish between hospitals and long-term care facilities that have been assisted under the Act.

The Hill-Burton program began in 1946 to provide federal aid to build and modernize hospitals. In 1954, nonprofit nursing homes were included in the program. More than 500 nursing homes in virtually every state in the nation have benefited from aid delivered through the Hill-Burton Act.

As a condition for receiving Hill-Burton funds, a facility must assure the government that it will provide a reasonable amount of uncompensated care to poor persons and that it will remain accessible to persons residing in the surrounding community. In 1979, the Department of Health and Human Services significantly changed the requirements for compliance with these two Hill-Burton obligations. The Department has indicated that the primary target of the new regulations that were adopted in 1979 were hospitals that were failing to live up to their Hill-Burton obligations.

Many of the nonprofit nursing homes that received Hill-Burton assistance have expressed concern that the regulations adopted by H.H.S. in 1979 failed to properly distinguish between hospitals and long-term care facilities. Due to differences in the length of stay, the makeup of the population and other factors, long-term care facilities face significantly different conditions and problems than hospitals. These long-term care facilities do not want to shirk their responsibility to provide reasonable amounts of uncompensated care, but they are concerned that their overall ability to meet their Hill-Burton obligations is compromised by the regulations which fail to recognize the differences between hospitals and nursing homes.

This section would direct the Secretary of H.H.S. to study the matter and to report to the Congress on whether there should be regulations or legislation distinguishing between hospitals and nursing homes that have participated in the Hill-Burton program. The Secretary is directed to report to the Congress by November 1, 1984, and to address the question of whether it would be appropriate to apply any distinctions that are necessary between the two types of facilities, in terms of fulfilling their Hill-Burton obligations, retroactively to September 1, 1979, the date of the major revision of the Hill-Burton regulations.

V. Tabulation of Votes Cast in Committee

In Executive Session of the Committee on Labor and Human Resources on Wednesday, March 21, 1984, the chairman's substitute for S. 2301 as introduced on February 9, 1984, was offered. Senator Edward M. Kennedy offered an amendment to increase the authorized level of funding for the preventive health services and health services block grant by approximately $4,000,000 per year for fiscal year 1985–1987. The amendment passed on a roll call vote as follows:

For	*Against*
Senator Kennedy	Senator Hatch
Senator Randolph	Senator Quayle
Senator Eagleton	Senator Nickles
Senator Pell	Senator Thurmond
Senator Metzenbaum	Senator Denton
Senator Matsunaga	Senator Grassley
Senator Riegle	Senator East
Senator Dodd	Senator Hawkins
Senator Weicker	
Senator Stafford	

By a voice vote the Committee amended the bill to increase the authorized level of funding for the Childhood Immunization program by $7,400,000 in fiscal year 1985, $9,500,000 in fiscal year 1986, and $11,000,000 in fiscal year 1987.

The chairman's substitute bill for S. 2301, as amended, was then recommended to be reported out of committee without dissent by voice vote.

VI. Cost Estimate

U.S. Congress,
Congressional Budget Office,
Washington, D.C., April 5, 1984.

The Honorable Orrin G. Hatch,
Chairman, Committee on Labor and Human Resources,
United States Senate, Washington, D.C.

Dear Mr. Chairman: The Congressional Budget Office has prepared the attached cost estimate for S. 2301, the Health Services, Preventive Health Services, and Home and Community-Based Services Act of 1984, as ordered reported by the Senate Committee on Labor and Human Resources on March 21, 1984.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

Rudolph G. Penner, *Director.*

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: S. 2301.
2. Bill title: The Health Services, Preventive Health Services, and Home and Community-Based Services Act of 1984.
3. Bill status: As ordered reported by the Senate Committee on Labor and Human Resources on March 21, 1984.

4. Bill purpose: This bill would revise and extend programs that provide health services and preventive health services. It would also establish a program that would provide home and community-based services.

5. Estimated cost to the Federal Government:

[By fiscal year, in millions of dollars]

	1985	1986	1987	1988	1989
Authorization level:					
Childhood immunizations	35.0	37.5	40.0	.....	.....
Tuberculosis	8.0	9.0	10.0	.....	.....
Venereal disease	50.0	55.0	55.0	.....	.....
Home health services:					
Grants and loans for the initial cost of home health agencies	5.0	5.0	5.0	.....	.....
Grants and contracts for training	2.0	2.0	2.0	.....	.....
Preventive health services block grant	89.0	93.5	98.1	.....	.....
Emergency medical services	2.0	2.0	2.0	.....	.....
State planning for health promotion and disease prevention	5.0	5.0	5.0	.....	.....
Home and community-based services	20.0	150.0	200.0	200.0	.....
Total authorization levels	216.0	359.0	417.1	200.0	.....

[By fiscal year, in millions of dollars]

	1985	1986	1987	1988	1989
Estimated outlays:					
Childhood immunizations	27.3	33.5	38.3	8.4	3.9
Tuberculosis	6.2	8.0	9.5	2.1	1.0
Venereal disease	39.1	48.9	53.3	11.9	5.5
Home health services:					
Grants and loans for the initial cost of home health agencies	4.6	4.9	5.0	0.4	0.1
Grants and contracts for training	1.8	1.9	2.0	0.2	0.1
Preventive health services block grant	49.7	91.5	96.1	43.4	.....
Emergency medical services	2.0	2.0	2.0	.....	.....
State planning for health promotion and disease prevention	3.3	4.2	4.8	1.7	0.8
Home and community-based services	20.0	150.0	200.0	200.0	.....
Total estimated outlays	154.0	344.9	411.0	268.1	11.4

The costs of this bill fall within budget function 550.

Basis of Estimate: All authorization levels are stated in the bill. We assume authorized amounts are fully appropriated at the beginning of each fiscal year. Outlays are estimated using spendout rates computed by CBO on the basis of appropriate recent program data.

6. Estimated cost to state and local governments: The budgets of state and local governments would not be greatly affected by the enactment of this bill. It is possible that funds authorized in this bill could be used as a substitute for state and local funds currently being spent for these services. However, this is not the intent of the legislation. For the two largest programs, the Preventive Health Services Block Grant and Home and Community-Based Services, S. 2301 states specifically that these funds will supplement current levels and in no way supplant state, local and other non-federal funds.

7. Estimate comparison: None.
8. Previous CBO estimate: None.
9. Estimate prepared by: Carmela Pena.
10. Estimate approved by: C. G. Nuckols (for James L. Blum, Assistant Director for Budget Analysis Division).

VII. Regulatory Impact Statement

The Committee believes the current block grant approach to providing preventive health services has been successful in significantly diminishing the paper work and regulatory burden required by previous categorical federal preventive health programs. Reauthorization of this block grant will continue this relief by giving states more flexibility and requiring less reporting of specific activities. However, in order to better assess the effectiveness and economy of the PHHS Block, the Secretary is required to develop model criteria and forms for the collection of data and information with respect to these services. There are no mandates for additional reporting. The new authority to provide grants for demonstration projects in pediatric emergency care, and state planning concerning health promotion and disease prevention will require development of guidelines and requests for proposals. The new authority for home and community based services requires the same reporting as the current PHHS block grant.

VIII. Family Fairness Statement

This Committee has determined that this bill has a significant influence on the family. Although the bill does not reference families directly, the introduction of the Home and Community-Based Health Care Blocks Grant provides essential support services to families caring for the disabled and the elderly. These services may include homemaker-home health aide services, nutrition services, occupational, physical and respiratory therapy, and emotional support to families who participate in the state programs. When families can care for their disabled and elderly members at home without undue burden, the family benefits.

With the primary focus of care taking place at home, families become more involved in the health of its members. This direct involvement empowers the family member to assist in the care instead of excluding them to feelings of helplessness. A patient surrounded by loving family members will feel better which enhances the treatment and promotes prevention.

Since the bill requires coordination among social and health service agencies and case management, families will find it easier to understand, utilize, and coordinate the services for the patient.

In general this bill improves family functioning by:

1. Including the family in treatment of a member.
2. Reducing the burdens of caring for sick/disabled patient at home by providing emotional and basic health services.
3. Increasing access to services in the community.
4. Coordinate existing social and health services.

IX. Section-by-Section Summary

Section 1 establishes the short title of the Act as the Health Services, Preventive Health Services, and Home and Community-Based Services Act of 1984.

REFERENCE

Section 2 provides that, except when otherwise specifically provided, whenever in the bill an amendment or repeal is expressed in terms of an amendment to or repeal of, a section or other provision, the reference shall be considered to be made to the Public Health Service Act.

CHILDHOOD IMMUNIZATION

Section 3 amends section 317(j)(1) of the PHS Act to extend the authorization of appropriations for childhood immunization programs for three years, at $42.4 million for FY 1985, $47 million for FY 1986, and $51 million for FY 1987.

PREVENTIVE HEALTH SERVICE PROGRAMS FOR TUBERCULOSIS

Section 4 amends section 317(j)(2) of the PHS Act to extend for three years the authorization of appropriations for preventive health service programs for tuberculosis, at $8 million for FY 1985, $9 million for FY 1986, and $10 million for FY 1987.

PROJECTS AND PROGRAMS FOR THE PREVENTION AND CONTROL OF VENEREAL DISEASE

Section 5 amends section 318(d)(1) of the PHS Act to extend for three years the authorization of appropriations for projects and programs for the prevention and control of venereal disease, at $50 million for FY 1985, and $55 million each year for FY 1986 and FY 1987.

HOME HEALTH SERVICE

Section 6 amends section 339 of the PHS Act to extend for three years through FY 1987 the authorization of $5 million a year for the establishment and operation of home health programs and $2 million a year for training programs in home health services.

PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT

Section 7(a) amends section 1901(a) of the PHS Act to extend for three years the authorization of appropriations for the Preventive Health and Health Services Block Grant, at $93 million for FY 1985, $97 million for FY 1986, and $102 million for FY 1987.

Section 7(b) amends section 1904(a)(1)(F) of the PHS Act to include in the list of activities for which funds under this block grant can be used by the States for the establishment, expansion, and improvement of emergency medical services for children who need treatment for trauma or critical care.

Section 7(c) amends section 1905(c) of the PHS Act by striking requirements that States:

1. Must award in FY 1982 emergency medical services grants and contracts to those entities which were funded in the State in FY 1981 and which would have been eligible for Federal assistance in FY 1982; and

2. Must agree to fund hypertension programs in FY 1982, 1983, and 1984 at specific percentages of the amounts spent in that State in FY 1981.

Section 7(d) repeals subsection (e) of section 1905 referring to the requirement in section 1905(c)(2) regarding grants for emergency medical services systems.

Section 7(e) adds a new subsection (d) to section 1906 of the PHS Act requiring the Secretary, in consultation with appropriate national organizations, to develop model criteria and forms for data and information collection with respect to services provided under this block grant in order to enable States to share uniform data and information on the provision of such services.

GRANTS TO STATES FOR DEMONSTRATION PROJECTS CONCERNING EMERGENCY MEDICAL SERVICES FOR CHILDREN

Section 8 amends part A of title XIX of the PHS Act (Preventive Health and Health Services Block Grant) by adding a new section 1909A which authorizes $2 million a year for FY 1985, 1986, and 1987 for the Secretary to make grants to not more than four States in a fiscal year to support a program of demonstration projects for the expansion and improvement of emergency medical services for children who need treatment for trauma or critical care. Such a grant shall be for a one-year period; the Secretary may renew a grant for an additional year only if the Secretary determines that such a renewal will provide significant benefits through the collection, analysis, and dissemination of information or data which will be useful to other States.

STATE PLANNING GRANTS

Section 9 further amends part A of title XIX of the PHS Act by adding a new section 1909B which authorizes $5 million each year for FY 1985, FY 1986, and 1987 for the Secretary to make grants to States to assist them to:

1. Develop long-range plans to achieve the goals, objectives, and priorities established by the Secretary pursuant to title XVII of the PHS Act (Health Information and Health Promotion);

2. Identify needs within States for services and activities that may be conducted with allotments under this block grant; and

3. Determine the progress of States in achieving the above-mentioned goals, objectives, and priorities, and to extent feasible, use scientifically valid measures to make such determinations.

HOME AND COMMUNITY-BASED SERVICES

Section 10(a) amends part A of title XIX of the PHS Act by adding a subpart 2—Home and Community-Based Services.

AUTHORIZATION OF APPROPRIATIONS

The new section 1910 authorizes appropriations for the Home and Community-Based Services Block. Grants to the States for the services and activities to be conducted under the new health block would first be authorized for fiscal year 1986. Authorizations are also provided for fiscal year 1987 and fiscal year 1988. For these grants to the States, $150 million is authorized for fiscal year 1986, $200 million for fiscal year 1987, and $200 million for fiscal year 1988. This section also authorizes $20 million for fiscal year 1985 for grants to the States for planning the implementation of the Home and Community-Based Services Block Grant.

ALLOTMENTS

New section 1910A(a) provides that for amounts appropriated for FY 1985, the Secretary shall allot $150,000 to each State, the District of Columbia, and Puerto Rico; and $50,000 to each of the territories. From the remainder of the amount appropriated in FY 1986, FY 1987, and FY 1988, the Secretary shall allot to each State an amount based on the ratio of the total number of elderly individuals residing in the State to the total number of elderly individuals in all States, multiplies by a weighting factor of the proportion of a State's population that is elderly compared to the proportion of the nation's population that is elderly. The total allotment for each State, the District of Columbia, and Puerto Rico in each of fiscal years 1986, 1987, and 1988, may not be less one-half of one percent of the total appropriation for that fiscal year. The allotments for the Virgin Islands, Guam, and the Trust Territory of the Pacific Islands for each fiscal year may not be less than one-fourth of one percent of the total appropriation for that fiscal year. The allotments for American Samoa and the Commonwealth of the Northern Mariana Islands for each fiscal year may not be less than one-sixteenth of one percent of the total appropriation for that fiscal year.

New section 1910A(b) provides that if any funds appropriated under this section and available for allotment are not allotted to States because:

1. One or more States have not submitted an application or description of activities as required;
2. One or more States have notified the Secretary that they do not intend to use the full amount of their allotment; or
3. Some State allotments are offset or repaid under section 1906(b)(3) of the PHS Act;

such excess shall be allotted among the remaining States in proportion to the to the amount otherwise allotted the States.

New Section 1910A(c) provides that if the Secretary receives a request from the governing body of an Indian tribe or tribal organization within a State that funds under this block grant be provided directly to such tribe or organization and the Secretary determines that the tribe or organization would be better served by direct grants, the Secretary may award funds directly to such tribe or organization. Such amounts would be reserved from a State's allotment and would be in the same proportion to the State's allotment for the fiscal year as the number of elderly individuals in the tribe

bears to the total number of elderly individuals residing in the State.

PAYMENT UNDER ALLOTMENTS TO STATES

The new section 1910B authorizes the Secretary to make payments to each State from amounts appropriated for the fiscal year. Any amount paid to a State for a fiscal year and remaining unobligated at the end of such year shall remain available to that State for the next fiscal year.

USE OF ALLOTMENTS

The new section 1910C(a) provides that amounts paid to a State under this block grant beginning in FY 1986 may be used for the following:

1. Activities to coordinate long-term care services provided to elderly and disabled individuals by public and private institutions and voluntary organizations in order to eliminate duplication and to maximize the use of funds;
2. The development of procedures and means to:
   a. Identify elderly and disabled individuals, including those who are patients in hospitals at risk of prolonged hospitalization who could be cared for in a long-term care institution or who could return to the community if services were available, or are patients in skilled nursing and intermediate care facilities who could return to the community if services were available;
   b. Identify geographic regions and population groups of such elderly and disabled individuals who do not have access to home and community-based services;
   c. Make recommendations for cost-effective measures to meet the needs of such elderly and disabled individuals for home and community-based services;
   d. Encourage and enhance the participation of families and voluntary organizations in providing home and community-based services for elderly and disabled individuals; and
   e. Develop and provide educational programs informing the public about all available home and community-based services.
3. Using the procedures and means developed under paragraph (2) above, the identification of elderly and disabled individuals who are patients in hospitals or in skilled nursing and intermediate care facilities as described in subparagraph (a) above and the preparation of recommendations for measures to meet their needs;
4. The conduct of activities to provide education and information to the public and to medical and social service professionals concerning home and community-based services provided by public and private institutions and organizations;
5. The provision to elderly and disabled individuals of:
   a. Homemaker or home health aide services provided by an individual trained in a program approved by the Secretary;

b. Medical social services under appropriate direction;

c. Dietary services provided by or under the supervision of a registered dietician;

d. Physical, occupational, speech, or respiratory therapy;

e. Adult day care services;

f. Drugs and biologicals when necessary for the elderly or disabled individual to receive other services in his or her place of residence;

g. Respite care services for a period not to exceed 14 days;

h. Any other supportive services, including patient and family training, which may be appropriate and necessary to prevent the institutionalization of an elderly or disabled individual, except that funds may not be used for the purchase of professional nursing or physician services; and

i. Case management services.

The new section 1910C(b) authorizes the States to give priority to the activities in paragraphs (1) through (4) of subsection (a) above in determining which activities to conduct with funds provided.

New section 1910C(c) authorizes the Secretary to provide technical assistance to States in planning and operating activities under this block grant.

New section 1910C(d) prohibits States from using funds paid to it under this block grant for:

1. Inpatient services;

2. Cash payments to intended recipients of health services, except that a State may use funds to establish a system of vouchers;

3. The pruchase or improvement of land, the purchase, construction, or improvement (other than minor remodeling) of any building or other facility, or the purchase of major medical equipment (except with special waiver);

4. Satisfying any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds; or

5. The provision of services under this block grant if the total cost of providing such services would exceed the total cost of institutionalization of such individual.

APPLICATION AND DESCRIPTION OF ACTIVITIES; REQUIREMENTS

The new section 1910D(a) requires a State to submit to the Secretary an application for a grant under the Home and Community-Based Block. The application would be submitted by the date and be submitted in the form required by the Secretary. In addition, each application would be required to contain assurances:

1. That the State legislature has complied with a requirement to conduct public hearings; and

2. That the State will meet various requirements specificed below.

The new section 1910(D)(b) requires the State legislature to conduct public hearings on the proposed use and distribution of funds received under the block. This requirement must be met for the

first year after fiscal year 1985 in which a State receives an allotment for home and community-based services and other activities.

The new section 1910D(c) requires, as part of the State's annual application, that the chief executive officer (for fiscal years after fiscal year 1985):

1. Certify that the State agrees to use its block grant funds according to the block's various requirements;

2. Provide assurances that an appropriate mechanism will be established to coordinate activities of State agencies which administer programs relating to health, welfare, rehabilitation, and the elderly and the provision of home and community-based services by State and local agencies and public and private institutions and organizations.

3. Provide assurances that a State agency will be designated or established to administer funds received under this block to ensure, to the maximum extent feasible, that needs of elderly and disabled persons will be met and that services provided will not duplicate services provided under other Federal authorities;

4. Certify that the State will coordinate home and community-based services provided under the block with services provided by voluntary, religious, and community organizations;

5. Provide assurances that the State will make reasonable efforts to provide services under this block grant through agencies and providers rendering services under the State's Medicaid plan; and

6. Certify that block grant funds will supplement and increase the level of State, local, and other non-Federal funds that would otherwise be available for home and community-based services, and will in no event supplant State, local, and other non-Federal funds.

The Secretary may not prescribe for a State the manner of compliance with the requirements of this subsection.

The new section 1910D(d) requires the chief executive officer of a State, as part of the State's application for a grant, to prepare and furnish to the Secretary a description of the intended use of block grant funds, including information on the programs, activities, and services to be supported. This description must be made public within the State in such a manner as to facilitate comment from any person (including any Federal or other public agency) during its development and after its transmittal. The description would be revised throughout the year as may be necessary to reflect substantial changes in programs and activities supported with block grant funds, and these changes would have to be made public in order to facilitate comment.

The new section 1910(e) specifies that certain other general provisions in title XIX for Health Block Grants would apply to the Home and Community-Based Services Block, except when these are inconsistent with the new block. Provisions which would apply to the Home and Community-Based Services Block include reductions in a State's allotment for supplies, equipment, expenses of a Federal employee; reports and audits; withholding; nondiscrimination; and criminal penalty for false statements.

DEFINITIONS

The new section 1910E defines "elderly individual" as one who has attained the age of 65 years. It specifies that the terms "Indian tribe" and "tribal organization" have the same meaning given such terms in section 4(b) and section 4(c) of the Indian Self-Determination and Education Assistance Act.

Section 10(b) of the bill amends the heading of Part A of title XIX of the PHS Act to read: "Part A—Preventive Health, Health Services, and Home and Community-Based Services," and by adding after the new heading the following: "Subpart 1—Preventive Health and Health Services".

It also strikes out references to "this part" in certain places where they appear in part A of title XIX and replaces them with "this subpart."

X. Changes in Existing Law

In compliance with rule XXVI paragraph 12 of the Standard Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

Public Health Service Act

TITLE I—SHORT TITLE AND DEFINITIONS

SHORT TITLE

This Act may be cited as the "Health Services, Preventive Health Services, and Home and Community-Based Services Act of 1984".

* * * * * * *

TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

* * * * * * *

Sec. 317. * * *

(j)(1) For grants under subsection (a) for preventive health service programs to immunize children against immunizable diseases there are authorized to be appropriated $29,500,000 for the fiscal year ending September 30, 1982, $32,000,000 for the fiscal year ending September 30, 1983, [and] $34,500,000 for the fiscal year ending September 30, 1984, *$42,400,000 for the fiscal year ending September 30, 1985, $47,000,000 for the fiscal year ending September 30, 1986, and $51,000,000 for the fiscal year ending September 30, 1987.*

(2) For grants under subsection (a) for preventive health service programs for tuberculosis there are authorized to be appropriated $9,000,000 for the fiscal year ending September 30, 1982, $10,000,000 for the fiscal year ending September 30, 1983, [and] $11,000,000 for the fiscal year ending September 30, 1984, *$8,000,000 for the fiscal year ending September 30, 1985, $9,000,000*

for the fiscal year ending September 30, 1986, and $10,000,000 for the fiscal year ending September 30, 1987.

SEC. 318. * * *

(d)(1) For the purpose of making grants under subsections (b) and (c) there are authorized to be appropriated $45,000,000 for the fiscal year ending September 30, 1979, $51,500,000 for the fiscal year ending September 30, 1980, $59,000,000 for the fiscal year ending September 30, 1981, $40,000,000 for the fiscal year ending September 30, 1982, $46,500,000 for the fiscal year ending September 30, 1983, [and] $50,000,000 for the fiscal year ending September 30, 1984, *$50,000,000 for the fiscal year ending September 30, 1985, $55,000,000 for the fiscal year ending September 30, 1986, and $55,000,000 for the fiscal year ending September 30, 1987.* For grants under subsection (b) in any fiscal year, the Secretary shall obligate not less than 5 per centum of the amount appropriated for such fiscal year under the preceding sentence. Grants made under subsection (b) or (c) of this section shall be made on such terms and conditions as the Secretary finds necessary to carry out the purposes of such subsection, and payments under any such grants shall be made in advance or by way of reimbursement and in such installments as the Secretary finds necessary.

SEC. 339. (a) * * *

"(5) There are authorized to be appropriated for grants and loans under this subsection $5,000,000 for each of the fiscal years ending September 30, 1983, [and] September 30, 1984, *September 30, 1985, September 30, 1986, and September 30, 1987.*

SEC. 339. (b) * * *

"(5) There are authorized to be appropriated for grants and contracts under this subsection $2,000,000 for each of the fiscal years ending on September 30, 1983, [and] September 30, 1984, *September 30, 1985, September 30, 1986, and September 30, 1987.*

TITLE XIX—BLOCK GRANTS

PART A—[PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT] *PREVENTIVE HEALTH, HEALTH SERVICES, AND HOME AND COMMUNITY-BASED SERVICES*

Subpart 1—Preventive Health and Health Services

AUTHORIZATION OF APPROPRIATIONS

SEC. 1901. (a) For the purpose of allotments under section 1902, there is authorized to be appropriated $95,000,000 for fiscal year 1982, $96,500,000 for fiscal year 1983, [and] $98,500,000 for fiscal year 1984, *$93,000,000 for fiscal year 1985, $98,000,000 for fiscal year 1986, and $102,000,000 for fiscal year 1987.*

(b) Of the amount appropriated for any fiscal year under subsection (a), at least $3,000,000 shall be made available for allotments under section 1902(b).

SEC. 1902. * * *

(d)(1) If the Secretary—

(A) receives a request from the governing body of an Indian tribe or tribal organization within any State that funds under [this part] *this subpart* be provided directly by the Secretary to such tribe or organization, and

(B) determines that the members of such tribe or tribal organization would be better served by means of grants made directly by the Secretary under [this part,] *this subpart,*

the Secretary shall reserve from amounts which would otherwise be allotted to such State under subsection (a) for the fiscal year the amount determined under paragraph (2).

* * * * * * *

USE OF ALLOTMENTS

SEC. 1904. (a)(1) Except as provided in subsections (b) and (c), amounts paid to a State under section 1903 from its allotment under section 1902(a) and amounts transferred by the State for use under [this part] *this subpart* may be used for the following:

* * * * * * *

[(F) Feasibility studies and planning for emergency medical services systems and the establishment, expansion, and improvement of such systems. Amounts for such systems may not be used for the costs of the operation of the systems or the purchase of equipment for the systems.]

(F) Feasibility studies and planning for emergency medical services systems and the establishment, expansion and improvement of such systems, including the establishment, expansion, and improvement of emergency medical services for children who need treatment for trauma or critical care. Amounts for such systems may not be used for the costs of operation of the systems.

(3) The Secretary may provide technical assistance to States in planning and operating activities to be carried out under [this part] *this subpart.*

(b) A State may not use amounts paid to it under section 1903 to—

(1) provide inpatient services,

(2) make cash payments to intended recipients of health services,

(3) purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment,

(4) satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds, or

(5) provide financial assistance to any entity other than a public or nonprofit private entity.

Except as provided in subsection (a)(1)(E), the Secretary may waive the limitation contained in paragraph (3) upon the request of a State if the Secretary finds that there are extraordinary circumstances to justify the waiver and that granting the waiver will assist in carrying out [this part] *this subpart.*

SEC. 1905. * * *

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(c) As part of the annual application required by subsection (a), the chief executive officer of each State shall certify that the State—

(1) agrees to use the funds allotted to it under section 1902 in accordance with the requirements of [this part;] *this subpart;*

[(2) except as provided in subsection (e), shall make grants for fiscal year 1982 to each entity within the State which received a grant or contract under section 1202, 1203, or 1204 in fiscal year 1981 and which would be eligible to receive a grant or contract under such section (as in effect on September 30, 1981) for such fiscal year if such grants or contracts were made under such section;]

[(3)] (*2*) agrees to establish reasonable criteria to evaluate the effective performance of entities which receive funds from the allotment of the State under [this part] *this subpart* and procedures for procedural and substantive independent State review of the failure by the State to provide funds for any such entity;

[(4) agrees to make grants for preventive health service programs for hypertension in amounts equal to—

[(A) for fiscal year 1982, 75 percent of the total amount provided by the Secretary in fiscal year 1981 to the State and entities in the State under section 317 for such programs,

[(B) for fiscal year 1983, 70 percent of such total amount, and

[(C) for fiscal year 1984, 60 percent of such total amount.]

[(5)](*3*) agrees to permit and cooperate with Federal investigations undertaken in accordance with section 1907;

[(6)](*4*) has identified those populations, areas, and localities in the State with a need for the services for which funds may be provided by the State under [this part;] *this subpart;*

[(7)](*5*) agrees that Federal funds made available under section 1903 for any period will be so used as to supplement and increase the level of State, local, and other non-Federal funds that would in the absence of such Federal funds be made available for the programs and activities for which funds are provided under that section and will in no event supplant such State, local, and other non-Federal funds; and

[(8)](*6*) has in effect a system to protect from inappropriate disclosure patient and rape victim records maintained by the State in connection with an activity funded under this part or by any entity which is receiving payments from the allotment of the State under [this part.] *this subpart.*

The Secretary may not prescribe for a State the manner of compliance with the requirements of this subsection.

* * * * * * *

[(e) A State shall be required to make a grant to an entity as prescribed by subsection (c)(2) unless—

[(1) the State recommends on the basis of—

[(A) any Federal finding, Federal administrative action, or judicial proceeding with respect to any such entity, or

[(B) a review of such entity in accordance with the criteria and procedures required under subsection (c)(3),

that the State not be required to make such grants; and

[(2) the Secretary approves the recommendation of the State under paragraph (1) based upon a substantive and procedural review of the record made by the State in making its recommendation under paragraph (1).] Repealed.

SEC. 1906. * * *

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(c) Title XVII of the Omnibus Budget Reconciliation Act of 1981 shall not apply with respect to audits of funds allotted under this part.

(d) The Secretary, in consultation with appropriate national organizations, shall develop model criteria and forms for the collection of data and information with respect to services provided under this part in order to enable States to share uniform data and information with respect to the provision of such services.

EMERGENCY MEDICAL SERVICES FOR CHILDREN

SEC. 1909A. (a) For activities in addition to the activities which may be carried out by States under section 1904(a)(1)(F), the Secretary may make grants to not more than four States in any fiscal year to support a program of demonstration projects in such States for the expansion and improvement of emergency medical services for children who need treatment for trauma or critical care. Any grant made under this section shall be for a one-year period.

(b) The Secretary may renew a grant made under this section to a State for one additional one-year period only if the Secretary determines that renewal of such grant will provide significant benefits through the collection, analysis, and dissemination of information or data which will be useful to other States.

(c) To carry out this section, there are authorized to be appropriated $2,000,000 for fiscal year 1985 and each of the two succeeding fiscal years.

STATE PLANNING CONCERNING HEALTH PROMOTION AND DISEASE PREVENTION

SEC. 1909B. (a) The Secretary may make grants to assist States to—

(1) develop long range plans to achieve the goals, objectives, and priorities established by the Secretary pursuant to title XVII;

(2) identify particular needs within States for services and activities that may be conducted with payments made under allotments under section 1902; and

(3) determine the progress of States in achieving the goals, objectives, and priorities described in paragraph (1) and, to the extent feasible, use scientifically valid measures to make such determinations.

(b) To carry out this section, there are authorized to be appropriated $5,000,000 for each of the fiscal years 1985, 1986, and 1987.

Subpart 2—Home and Community-Based Services

AUTHORIZATIONS OF APPROPRIATIONS

Sec. 1910. (a) For the purpose of allotments to States to carry out the activities described in section 1910C, there are authorized to be appropriated $150,000,000 for fiscal year 1986, $200,000,000 for fiscal year 1987, and $200,000,000 for fiscal year 1988.

(b) For the purpose of allotments to States for planning the implementation of this subpart, there are authorized to be appropriated $20,000,000 for fiscal year 1985.

ALLOTMENTS

Sec. 1910A. (a)(1) From the amounts appropriated under section 1910 for fiscal year 1985, the Secretary shall allot—

(A) $150,000 to each of the several States, the District of Columbia, and Puerto Rico; and

(B) $50,000 to each of American Samoa, the Virgin Islands, the Commonwealth of the Northern Mariana Islands, Guam, and the Trust Territory of the Pacific Islands.

(2) Except as provided in paragraph (3), the Secretary shall allot to each State, from the remainder of the amounts appropriated under section 1910 for fiscal year 1985 which have not been allotted under paragraph (1), and from the amounts appropriated under such section for fiscal years 1986, 1987, 1988, an amount for each such fiscal year equal to the product of—

(A) the total amount of such remainder for fiscal year 1985 or the total amount appropriated for fiscal year 1986, 1987, or 1988, as the case may be, multiplied by

(B) the ratio (stated as a percentage) that the total number of elderly individuals residing in the State bears to the total number of elderly individuals residing in the United States, multiplied by

(C) the quotient of—

(i) the ratio (stated as a percentage) that the total number of elderly individuals residing in the State bears to the total population of the State, divided by

(ii) the ratio (stated as a percentage) that the total number of elderly individuals residing in the United States bears to the total population of the United States.

(3) Notwithstanding paragraph (2)—

(A) the total amount of the allotment for each of the several States, the District of Columbia, and Puerto Rico for each of the fiscal years 1986, 1987, and 1988 shall not be less than one-half of 1 percent of the total amount appropriated under section 1910 for such fiscal year;

(B) the total amount of the allotment for each of the Virgin Islands, Guam, and the Trust Territory of the Pacific Islands for each such fiscal year shall not be less than one-fourth of 1 percent of the total amount appropriated under section 1910 for such fiscal year; and

(C) the total amount of the allotment for each of American Samoa and the Commonwealth of the Northern Mariana Islands for each such fiscal year shall not be less than one-sixteenth of 1 percent of the total amount appropriated under section 1910 for such fiscal year.

(b) To the extent that all the funds appropriated under section 1910 for a fiscal year and available for allotment in such fiscal year are not otherwise allotted to States because—

(1) one or more States have not submitted an application or description of activities in accordance with section 1910D for such fiscal year;

(2) one or more States have notified the Secretary that they do not intend to use the full amount of their allotment; or

(3) some State allotments are offset or repaid under section 1906(b)(3) (as such section applies to this subpart pursuant to section 1910D(e));

such excess shall be allotted among each of the remaining States in proportion to the amount otherwise allotted to such States for such fiscal year without regard to this subsection.

(c)(1) If the Secretary—

(A) receives a request from the governing body of an Indian tribe or tribal organization within any State that funds under this subpart be provided directly by the Secretary to such tribe or organization, and

(B) determines that the members of such tribe or tribal organization would be better served by means of grants made directly by the Secretary under this subpart,

the Secretary shall reserve from amounts which would otherwise be allotted to such State under subsection (a) for a fiscal year the amount determined under paragraph (2).

(2) The Secretary shall reserve for the purpose of paragraph (1) from amounts that would otherwise be allotted to such State under subsection (a) an amount equal to the amount which bears the same ratio to the State's allotment for the fiscal year involved under subsection (a) as the total number of elderly individuals in the tribe during such fiscal year bears to the total number of elderly individuals residing in the State during such fiscal year.

(3) The amount reserved by the Secretary on the basis of a determination under this subsection shall be granted to the Indian tribe or tribal organization serving the elderly individuals and disabled individuals for whom such a determination has been made.

(4) In order for an Indian tribe or tribal organization to be eligible for a grant for a fiscal year under this subsection, it shall submit to the Secretary a plan for such fiscal year which meets such criteria as the Secretary may prescribe.

PAYMENTS UNDER ALLOTMENTS TO STATES

SEC. 1910B. (a) For each fiscal year, the Secretary shall make payments, as provided by section 6503(a) of title 31, United States Code, to each State from its allotments under section 1910A (other than any amount reserved under subsection (c) of such section) from amounts appropriated for that fiscal year.

(b) Any amount paid to a State for a fiscal year and remaining unobligated at the end of such year shall remain available for the next fiscal year to such State for the purposes for which it was made.

USE OF ALLOTMENTS

SEC. 1910C. (a) Except as provided in subsection (c), amounts paid to a State under section 1910B from its allotment under section 1910A for any fiscal year beginning after September 30, 1985, may be used for the following:

(1) Activities to coordinate long-term care services provided to elderly individuals and disabled individuals by public and private institutions and voluntary organizations in order to eliminate duplication in the provision of such services and to maximize the use of funds provided under this subpart and other Federal laws for such services.

(2) The development of procedures and means to—

(A) identify elderly individuals and disabled individuals, including elderly individuals and disabled individuals who are—

(i) patients in hospitals who are at risk of prolonged hospitalization and who could be cared for in a long-term care institution or who could return to the community if home and community-based services are available; and

(ii) patients in skilled nursing facilities and intermediate care facilities who could return to the community if home and community-based services were available;

(B) identify geographic regions and population groups of such elderly individuals and disabled individuals who do not have access to home and community-based services;

(C) make recommendations for cost-effective measures to meet the needs of such elderly individuals and disabled individuals for home and community-based services;

(D) encourage and enhance the participation of families and voluntary organizations in providing home and community-based services for elderly individuals and disabled individuals; and

(E) develop and provide educational programs informing the public about all available home and community-based services.

(3) Pursuant to the procedures and means developed under paragraph (2), the identification of elderly individuals and disabled individuals described in subparagraph (A) of such paragraph, and for each elderly individual or disabled individual identified, the preparation of the recommendations described in subparagraph (C) of such paragraph.

(4) The conduct of activities to provide education and information to the public and to medical and social service professionals concerning home and community-based services provided by public and private institutions and organizations.

(5) The provision to elderly individuals and disabled individuals of—

(A) homemaker or home health aide services provided by an individual who has successfully completed a training program approved by the Secretary;

(B) medical social services under appropriate direction;

(C) dietary services provided by or under the supervision of a registered dietitian;

(D) physical, occupational, speech, or respiratory therapy;

(E) adult day care services;

(F) drugs and biologicals when necessary for an elderly individual or a disabled individual to receive in the home of such individual other services provided under this subpart;

(G) respite care services for a period not to exceed fourteen days;

(H) any other supportive services, including patient and family training, which may be appropriate and necessary to prevent the institutionalization of an elderly individual or a disabled individual, except that funds provided to a State under this subpart shall not be used for the purchase of professional nursing or physician services; and

(I) case management services.

(b) In determining which activities to conduct with funds provided under this subpart, a State shall give priority to the activities described in paragraphs (1) through (4) of subsection (a).

(c) The Secretary may provide technical assistance to States in planning and operating activities to be carried out under this subpart.

(d) A State may not use amounts paid to it under section 1910B to—

(1) provide inpatient services;

(2) make cash payments to intended recipients of services, except that a State may use amounts paid to it under section 1910B to establish a system under which—

(A) the State provides vouchers to elderly individuals and disabled individuals which may be used by such individuals to pay providers of services described in subsection (a) for such services; and

(B) such providers present such vouchers to the State for redemption for cash payments for the provision of such services;

(3) purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility or purchase major medical equipment; or

(4) satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds; or

(5) provide services under this part to an individual if the total cost of providing such services would exceed the total cost of institutionalization of such individual.

The Secretary may waive the limitation contained in paragraph (3) with respect to a fiscal year beginning after September 30, 1985, upon the request of a State if the Secretary finds that there are extraordinary circumstances to justify the waiver and that granting the waiver will assist in carrying out this subpart.

APPLICATION AND DESCRIPTION OF ACTIVITIES; REQUIREMENTS

SEC. 1910D. (a)(1) In order to receive an allotment for a fiscal year under section 1910A each State shall submit an application to the Secretary. Each such application shall be in such form and submitted by such date as the Secretary shall require.

(2) Each application required under paragraph (1) for an allotment under section 1910A for a fiscal year beginning after September 30, 1985, shall contain assurances that the legislature of the State has complied with the provisions of subsection (b) and that the State will meet the requirements of subsection (c).

(b) After the expiration of the first fiscal year beginning after September 30, 1985, for which a State receives an allotment under section 1910A, no funds shall be allotted to such State for any fiscal year under such section unless the legislature of the State conducts public hearings on the proposed use and distribution of funds to be provided under section 1910B for such fiscal year.

(c) As part of the annual application required by subsection (a) for an allotment for a fiscal year beginning after September 30, 1985, the chief executive officer of each State shall—

(1) certify that the State agrees to use the funds allotted to it under section 1910A in accordance with the requirements of this subpart;

(2) provide assurances that such chief executive officer will establish an appropriate mechanism to coordinate activities of State agencies which administer programs relating to health, welfare, rehabilitation, and the elderly and the provision of home and community-based services by State and local agencies and public and private institutions and organizations;

(3) provide assurances that such chief executive officer will designate or establish a State agency to administer funds provided under this subpart and the plan developed under paragraph (2) in a manner which will insure, to the maximum extent feasible—

(A) that the needs of elderly individuals and disabled individuals for home and community-based services identified under section 1910(a)(3) will be met; and

(B) that services provided to elderly individuals and disabled individuals under this subpart will not duplicate services to elderly individuals and disabled individuals provided under other provisions of Federal law;

(4) certify that the State will coordinate the provision of home and community-based services with funds provided under this subpart with activities conducted to provide such services by voluntary, religious, and community organizations and local governments;

(5) provide assurances that the State will make reasonable effects to provide services under this subpart through agencies and providers rendering services under the State's medicaid plan approved under title XIX of the Social Security Act; and

(6) certify that the State agrees that Federal funds made available under section 1910B for any period will be so used as to supplement and increase the level of State, local, and other non-Federal funds that would in the absence of such Federal

funds be made available for the programs and activities for which funds are provided under that section and will in no event supplant such State, local, and other non-Federal funds. The Secretary may not prescribe for a State the manner of compliance with the requirements of this subsection.

(d) The chief executive officer of a State shall, as part of the application required by subsection (a) for any fiscal year beginning after September 30, 1985, also prepare and furnish the Secretary (in accordance with such form as the Secretary shall provide) with a description of the intended use of the payments the State will receive under section 1910B for the fiscal year for which the application is submitted, including information on the programs and activities to be supported and services to be provided. The description shall be made public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during development of the description and after its transmittal. The description shall be revised (consistent with this section) throughout the year as may be necessary to reflect substantial changes in the programs and activities assisted by the State under this subpart, and any revision shall be subject to the requirements of the preceding sentence.

(e) Except where inconsistent with the provisions of this subpart, the provisions of section 1903(b), section 1906 (a), paragraphs (1) through (5) of section 1906 (b), and sections 1907, 1908, and 1909 shall apply to this subpart in the same manner as such provisions apply to subpart 1 of this part.

DEFINITIONS

SEC. 1910E. For purposes of this subpart—

(1) The term "elderly individual" means an individual who has attained the age of 65 years.

(2) The terms "Indian tribe" and "tribal organization" have the same meaning given such terms in section 4(b) and section 4(c) of the Indian Self-Determination and Education Assistance Act.

XI. ADDITIONAL VIEWS OF SENATOR EDWARD M. KENNEDY

I am pleased that this bill establishes a new planning grant authority to help States design an effective prevention effort. A new planning grant authority for prevention was included in the omnibus health services and health services research reauthorization bill that I introduced on March 20 and that was cosponsored by all the Democratic members of the Labor and Human Resources Committee. A systematic planning and reporting effort is essential to an effective prevention effort.

While this bill is a step in the right direction, it does not go far enough. Lacking are adequate funding levels, a planning requirement, and a mandated reporting system to assure measurement of progress toward national prevention goals.

Since the days when I first attempted to place health promotion and disease prevention at the center of our national health agenda, there has been a growing recognition that a comprehensive, aggressive prevention strategy can be our most effective weapon in the struggle to secure health and well-being for the American people. As Assistant Secretary Brandt recently stated, "the time has come for us to turn our attention as a nation to the preservation of good health, the promotion and enhancement of healthful life-styles, and the prevention of disease and disability."

The knowledge base for rapid improvements in the health of the American people through an effective prevention strategy is now in place. The 1979 Surgeon General's report, "Healthy People," identified major health problems for each of five broad age groups and fifteen priority areas for further action. The Surgeon General's 1980 follow-up report, "Promoting Health/Preventing Disease," established 226 measureable prevention objectives for these 15 priority areas. The Center for Disease Control has developed model prevention standards for community health services. The prevention-oriented activities of the public health service have been inventoried and given renewed emphasis.

Implementation of the goals outlined in this series of reports will result in dramatic improvements in the health and well-being of the American people. By the end of this decade, we can anticipate:

—a 35% reduction in infant mortality
—a 20% drop in deaths among children
—a 20% decline in adolescent deaths
—a 25% lower death rate among adults, and
—20% less disability for older Americans.

But these lower death and disability rates and all they imply for healthier, happier, more active and productive lives will not occur simply because we have a roadmap showing how to get from here to there. An aggressive national policy can help us not only achieve but surpass these goals.

The major missing ingredient in our national prevention strategy has been the lack of an effective Federal-State partnership to assure comprehensive prevention planning and service delivery at the State and community level where people can be reached most effectively.

The preventive health block grant should be the key vehicle for development of an effective Federal-State partnership. Instead, this block grant is an example of the Reagan so-called "New Federalism" at its worst. Essentially a thinly disguised attempt to eliminate the Federal responsibility for a grab-bag of categorical programs, this block was established without standards, priorities, accountability, measurement, or a clear relationship to either national or local objectives.

I believe this block grant should be restructured into an effective vehicle for achieving the goals and objectives established in the Surgeon General's report. As a condition for reducing block grant funds States should be required to go through a conscious prevention planning process to establish goals and objectives in each of the Surgeon General's fifteen preventive areas, to establish at least one high priority prevention objective for each of the five age groups identified in "Healthy People," and to develop a plan for meeting the priority objectives selected by the State itself utilizing not only PHS funds, but other appropriate public and private resources, and to measure progress toward fulfillment of the State plan and national prevention goals. As the witness from the Association of State and Territorial Health Officer stated, "We want to be held accountable."

A number of States, including my own State of Massachusetts, Utah, and Texas have already gone through this process of establishing comprehensive State prevention plans and developing a measurement and reporting system to ensure the plan objectives are achieved.

In addition to the lack of a comprehensive planning and reporting requirement, the funding levels in the bill are not high enough. All the witnesses before this Committee who dealt with the question of funding indicated—Federal support was inadequate. Prevention is our most cost-effective health investment; it does not make good sense to spend over one hundred billion dollars on Federal service and financing programs and less than one hundred million dollars on the prevention block grant.

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